**Iowa *Care for Yourself* - WISEWOMAN**
**APPLICATION FOR HEALTH CARE FACILITY & HEALTH CARE PROVIDER ENROLLMENT**

**CHECK ALL SERVICE TYPE(S) THAT APPLY:** ☐ Clinic ☐ Private Practice ☐ Hospital ☐ Lab

**Tax ID #** _____ **NPI #** _____

**FACILITY** (Use official name/DBA) This is the location where services will be performed

**Facility Name** _____

**Facility Mailing Address** _____

_____

**Physical Address** (If different) _____

_____

**Facility Telephone** (___) _____ **Facility Fax** (___) _____

**Facility Contact Person** _____ **Title** _____

**Telephone (___)** _____ **Email Address** _____

**BILLING AGENCY** - Address where payments should be mailed

☐ **Check the box if the billing agency address is the same as the Facility Mailing Address.**

☐ **Check the box if the Billing Agency NPI# is the same as the Facility NPI#. If different, please list below:**

**NPI #** _____

**Billing Agency Name** _____

**Billing Agency Mailing Address (if different from Facility)** _____

_____

**Billing Telephone** (___) _____ **Billing Fax (___)** _____

**Billing Contact Person** _____ **Title** _____

**Telephone** (___) _____ **Email Address** _____

**SPECIAL REQUIREMENTS:** All service Providers and facilities must be enrolled in the Care for Yourself – WISEWOMAN program to receive reimbursement for services.

Identified facilities listed below need to complete a separate Cooperative Agreement and Application for Health Care Facility & Health Care Provider Enrollment if not associated with the same Tax ID Number listed above. This will help ensure that eligible participants receive program services without being billed and health care facilities and health care providers receive appropriate reimbursement.

**Laboratory** name, address, phone _____

_____

_____

_____

**PARTICIPATING CFY – WISEWOMAN HEALTH CARE PROVIDERS**

| **Facility Tax ID #** | | |
|---|---|---|
| **NAME(S) -** Print the name of each participating **health care provider** that may bill the program. Include **credentials.** | **LICENSE/ CERTIFICATE NUMBER** | **NPI NUMBER** |
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AMENDMENTS: Any changes to this agreement will be valid only if made in writing and accepted by all parties to this agreement.

EFFECTIVE DATES: This agreement shall be in effect from CORPORATION/LEAD FACILITIES receipt of this contract signed by the DEPARTMENT for a term of six (6) years, or until terminated.

_____

Authorized Facility Signature

_____

Date